

Utah Medicaid Provider Manual	Targeted Case Management for Early Childhood (Ages 0-4)
Division of Health Care Financing	Updated January 2007

SECTION 2

Early Childhood (Ages 0-4) Targeted Case Management

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1 GENERAL POLICY

Targeted case management is a service that assists eligible clients in the target group to gain access to needed medical, social, educational, and other services. The overall goal of the service is not only to help Medicaid recipients to access needed services, but to ensure that services are coordinated among all agencies and providers involved.

1 - 1 Authority

The Consolidated Omnibus Budget Reconciliation Act (P.L. 99-272, COBRA) added targeted case management to the list of optional services which can be provided under the State Medicaid Plan.

1 - 2 Definitions and Terms

CHEC: means Child Health Evaluation and Care and is Utah's version of the federally mandated Early Periodic screening Diagnosis and Treatment (EPSDT) program. All Medicaid eligible clients from *birth through age twenty* are enrolled in the CHEC program. The only exception to this policy is that Medicaid clients age 19 and older enrolled in the Non-Traditional Medicaid Plan are **not** eligible for the CHEC program. The Medicaid Identification Cards for individuals enrolled in the Non-Traditional Medicaid Plan are blue in color and specify that the individual is enrolled in this plan.

Medical Home: The term for the collaborative effort between a primary care provider, children and their families to ensure that care is accessible, family-centered, continuous, comprehensive, convenient, compassionate and culturally competent.

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1 - 3 Target Group

- A. Targeted case management services are a covered benefit for all Medicaid children. Case management services begin when the family is contacted and accepts services. Services continue until the case manager determines they are no longer needed or until the family voluntarily terminates services. Services are considered medically necessary when a needs assessment is completed by a qualified case manager and both conditions listed below are documented. (Refer to Chapter 1 - 4 for the definition of a case manager.)
1. The individual requires treatment or services from a variety of agencies or providers to meet his or her documented medical, social, educational and other needs; and
 2. There is reasonable indication the child will access needed treatment or services only if assisted by a qualified case manager who locates, coordinates and regularly monitors the services in accordance with the child's case management service plan.
- B. Currently, the Utah Medicaid program provides coverage of targeted and home and community based waiver services (HCBWS) case management for a variety of other target groups:
1. Individuals with Substance Abuse Disorders;
 2. Chronically Mentally Ill;
 3. Homeless individuals;
 4. Individuals with a diagnosis of HIV/AIDS;
 5. Individuals with Physical Disabilities (HCBS Waiver);
 6. Individuals with Mental Retardation/Related Conditions (HCBS Waiver);
 7. Individuals Age 65 and over (HCBS Waiver);
 8. Technology-Dependent Children (HCBS Waiver); and
 9. Individuals with Traumatic Brain Injury (HCBS Waiver).

There are separate rules and provider manuals to address the scope of services and reimbursement methods for the other target groups. Since a Medicaid client may qualify for targeted or waiver case management services under other target groups, it is imperative that before providing services, the case manager determine if other agencies are already providing targeted or waiver case management for the client, as only one targeted case management provider will be reimbursed for the same or overlapping dates of service. Coordination of all services is an essential component of targeted case management.

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1 - 4 Qualified Targeted Case Management Providers

Medicaid providers of targeted case management services for children include public health nurses employed by local health departments, which specialize in providing case management services to children, and defined as follows:

- A. Individual is licensed as a registered nurse in the state of Utah and employed by a local, state or district health department.
- B. Agency which specializes in providing case management services to children meets all four of the following criteria:
 - 1. Is authorized and responsible as outlined in Utah Code Section 17-5-243 to provide, directly or indirectly, basic public health services as outlined in Utah Code Section, 26A-1-106(3).
 - 2. Employs or contracts with registered nurses who perform case management assessments and follow-up services. The agency may use non-licensed individuals to provide follow-up case management services under the supervision of a registered nurse, if the individual has education and experience related to children and adolescents and has successfully completed a targeted case management course approved by the Division of Health Care Financing;
 - 3. Maintains documentation of required licensure or successful completion of the approved training course for individuals who render case management services; and
 - 4. Has an approved targeted case management Provider Agreement on file with the Division of Health Care Financing.

1 - 5 Targeted Case Management Training Curriculum With Local Health Departments

- A. As indicated in Chapter 1 - 4, item B, enrolled agencies may use non-licensed individuals to provide targeted case management services if the individual completes a targeted case management training program approved or conducted by the Division of Health Care Financing (DHCF). The DHCF will approve training programs which include all of the following components:
 - 1. Detailed instruction in the Medicaid targeted case management provider manual requirements and methods for delivering and documenting covered case management services;
 - 2. Training on the requirements of the Utah Medicaid Provider Manual for Child Health Evaluation and Care (CHEC) Services.
 - 3. Up-to-date information on community resources and how to access those resources; and
 - 4. Techniques and skills in communicating successfully with Medicaid recipients and other agency personnel.
- B. The agency must provide information and instruction using materials provided by the Division of Health Care Financing (DHCF). Materials, training, technical assistance and sources of information are available upon request.

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1 - 6 Client Rights

- A. Targeted case management services may not be used to restrict the child's access to other services available under the Medicaid State Plan.
- B. The provider agency must have a process to ensure that the child's parent/guardian voluntarily chooses targeted case management services and is given a choice in the selection of the targeted case manager if available.

1 - 7 Recognizing and Reporting Child Abuse

When any person, including persons licensed under title 58, Chapter 12, Part 5. Utah Medical Practice Act, or Title 58, Chapter 31, Nurse Practice Act, has reason to believe that a child has been subjected to incest, molestation, sexual exploitation, sexual abuse, physical abuse, or neglect, or who observes a child being subjected to conditions or circumstances which would reasonably result in sexual abuse, physical abuse, or neglect, he shall immediately notify the nearest peace officer, law enforcement agency, or the office of Child Protective Services.

1 - 8 Referrals to Program

A monthly report is distributed by the Department of Health, Division of Health Care Financing, Bureau of Managed Health Care, to the district and local health departments identifying pregnant women residing in their districts. These women are reporting pregnancy and have made application to Medicaid for services. This report will facilitate contact with Medicaid women for the purpose of offering services in this program.

1 - 9 Referrals to Community Resources

Referrals to community resources is perhaps the most important component of case management. Rather than fragmenting or duplicating services, the focus is to link the child with medical, social, educational and other services capable of addressing the needs of the child and to which the child is not currently receiving. When possible, a referral to holistic services should be considered. Local community resources, if available, are preferable to out-of-area providers. When considering resources to which a child might be referred, consideration of Medicaid reimbursement for the service should not be a factor in the selection of providers. Referrals for needed services and scheduling of appointments may be necessary and can be completed at some time after the initial assessment.

1 - 10 Initial Intake

After the local/district health department receives the newborn/pregnancy report, a Public Health Nurse or other worker will make an initial telephone contact with the Medicaid mother to offer services. When the mother accepts services, an Initial Intake Form is completed. It contains demographic information, directions to the home, primary language spoken by the family and any pertinent medical or nutritional information to help the nurse with case management activities prior to the visit. The nurse or person completing the form will schedule a home (or other suitable) visit and note the contact and the date of the scheduled initial visit on the form.

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1 - 11 Initial Home Visit

A Public Health Nurse will make an initial visit to the home (or other suitable location) of the child. During the visit he/she will complete the Initial Assessment Form. The initial visit should include activities that focus on the completion of the needs assessment.

1 - 12 Monitoring and Follow-up

Monitoring and follow-up include activities and contacts necessary to ensure the service plan is effectively implemented and adequately addresses the needs of the Medicaid child. These contacts may be with the child, family member, providers or others. Should monitoring or follow-up services be necessary, the public health nurse, in the role of a case manager, will collaborate with other providers to optimize services and avoid duplication. Based on the information gathered and the professional opinion of the nurse, a determination is made for follow-up services.

Contacts may be as frequent as necessary to help determine such things as:

1. Whether services are being furnished in accordance with the service plan.
2. Whether services are adequate to obtain the goal of the service plan.
3. Whether the needs or status of the child has changed, eligibility, referrals, etc.

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2 SCOPE OF SERVICE

2 - 1 Covered Services

- A. Targeted case management is a service to assist a Medicaid-eligible child in the target group to gain access to needed medical, social, educational, and other services. The goals of the service are to help the child access needed services and ensure services are coordinated among all agencies and providers involved. The family/care giver may be able to help identify needs and supports, assist the eligible child to obtain services, provide useful feedback and alert the case manager to changes. Adjustments in the care plan or service arrangements are sometimes necessary to provide a progressive level of care. These services are considered case management activities.
- B. Medicaid reimbursement for targeted case management is dictated by the nature of the activity and the purpose for which the activity was performed. When billed in reasonable amounts, given the needs and condition of a particular child, the following activities and services are covered by Medicaid under targeted case management:
 1. Assessing the client to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social or other services. Assessment activities include: taking client history, identifying the needs of the client and completing related documentation, gathering information from other sources such as family members, medical providers, social workers, other providers, and educators, if necessary, to form a complete assessment of the client;
 2. Developing a written, individualized, and coordinated case management service plan based on the information collected through an assessment that specifies the goals and actions to address the medical, social, educational, and other services needed by the client, with input from the client, the client's authorized health care decision maker, and others (e.g., the client's family, other agencies, etc.) knowledgeable about the client's needs, to develop goals and identify a course of action to respond to the assessed needs of the client;
 3. Referral and related activities to help the client obtain needed services, including activities that help link the client with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers of needed services and scheduling appointments for the client;
 4. Assisting the client to establish and maintain eligibility for entitlements **other than Medicaid** (see Chapter 2 - 3, item H);
 5. Coordinating the delivery of services to the client, including CHEC screenings and follow-up;
 6. Contacting non-eligible or non-targeted individuals when the purpose of the contact is directly related to the management of the client's care. For example, family members may be able to help identify needs and supports, assist the client to obtain services, provide case managers with useful feedback and alert them to changes in the client's status or needs;
 7. Monitoring and follow-up activities, including activities and contacts that are necessary to ensure the targeted case management service plan is effectively implemented and adequately addressing the needs of the client, which activities may be with the client, family members, providers, or other entities, and conducted as frequently as necessary to help determine such matters as whether services are being furnished in accordance with the client's case management service plan, whether the services in the case management service plan are adequate, whether there are changes in the needs or status of the client, and if so, making necessary adjustments in the case management service plan and service arrangements with providers; and
 8. Instructing the caretaker, as appropriate, in independently obtaining access to needed services for the child.

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- C. The agency may bill Medicaid for the above activities **only if**:
1. The activities are delineated in the case management service plan, and
 2. The time spent in the activity involves a face-to-face encounter, telephone or written communication with the child, family, caretaker, service provider, or other individual with a direct involvement in providing or assuring the child obtains the necessary services documented in the targeted case management service plan.

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2 - 2 Non-Covered Services and Activities

Medicaid case management services do not include direct services, such as medical, educational or social to which a child has been referred. For example, if a child is linked to a Medical Home, then any services provided by that Medical Home could not then be billed to case management. This includes physicals, for example. In accordance with federal Medicaid guidelines, **the following activities are not considered targeted case management and should not be billed to Medicaid:**

- A. Documenting targeted case management services. With the exception of time spent developing the written needs assessment, service plan and progress notes, documentation is not reimbursable.
- B. Teaching, tutoring, training, instructing, or educating the child or others, unless the activity is specifically designed to assist the child, parent or caretaker to independently obtain needed services for the child. When the purpose of the contact is directly related to the management of the child, then it is appropriate to have family members involved in all components related to the child's case management. For example, assisting the child to complete a homework assignment or instructing a child or family member on nutrition, budgeting, cooking, parenting skills or other skills development is not reimbursable. However, providing education that enables the child or family member to access these services is billable.
- C. Directly assisting with personal care or activities of daily living. For example, assisting with budgeting, cooking, shopping, laundry, apartment hunting, moving residences or acting as a protective payee are not reimbursable activities.
- D. Performing routine services including courier services. For example, running errands or picking up and delivering food stamps or entitlement checks are not reimbursable.
- E. Direct delivery of an underlying medical, educational, social or other service to which an eligible individual has been referred, or provision of a Medicaid-covered service. For example, providing medical and psycho-social evaluations, treatment, therapy and counseling that are otherwise billable to Medicaid under other categories of service, are not reimbursable as targeted case management.
- F. Direct delivery of foster care services, including but not limited to research gathering and completion of documentation required by the foster care program, assessing adoption placements, recruiting or interviewing potential foster care placements, serving legal papers, home investigations, providing transportation, administering foster care subsidies or making foster care placement arrangements.
- G. Traveling to the child's home or other location where a covered case management activity will occur is not reimbursable, nor is time spent transporting a child or a child's family members.
- H. Providing services for or on behalf of other family members who do not directly assist the child to access needed services. For example, counseling the child's sibling or helping the child's parent obtain a mental health service are not reimbursable.
- I. Performing activities necessary for the proper and efficient administration of the Medicaid State Plan, including assisting the child to establish and maintain Medicaid eligibility. For example, locating, completing and delivering documents to the Medicaid eligibility worker are not reimbursable.
- J. Recruitment activities in which the agency or case manager attempts to contact potential recipients of service are not reimbursable.

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2 - 3 Limitations on Reimbursable Services

A. Team Case Management

Targeted case management services provided to a child by more than one case manager employed by or contracted with the same agency or program is reimbursable only when all the following conditions are met:

1. All members of the team meet the qualifications described in Chapter 1 - 4, Qualified Targeted Case Management Providers.
2. Documentation of billed services is maintained in a single case file.
3. All services are delivered under a single case management service plan.
4. All team members coordinate with one another to ensure only necessary, appropriate and unduplicated services are delivered by all team members.
5. Time spent by two or more members of the team in the same targeted case management activity may be billed only by one team case manager.
6. The family is informed of and understands the roles of the team members.

B. Shared Case Management

Targeted case management services billed by case managers from more than one agency or program during the same or overlapping dates of service for the same child will be considered for reimbursement only if the DHCF has received documentation to support the need for the expertise of two case management providers. A letter signed by the case managers of both agencies must be submitted to the DHCF. The letter must (1) fully explain the need for shared case management, (2) document the specific and **non-duplicative** services to be provided by each case manager, (3) specify the time period during which shared case management will be required, and (4) include a copy of the needs assessments and service plans from both case managers and a written statement from the Local Interagency Council (LIC) or the Local Interagency Coordinating Council (LICC) if a council has reviewed the child's need for shared case management services.

If approved by the DHCF, case managers sharing case management responsibilities for a child may bill for their participation in LIC/LICC meetings for the time during which the child's needs are addressed.

NOTE: The DHCF will not approve shared case management for a child receiving home and community-based waiver services. Time spent on behalf of a client receiving home and community-based waiver case management services is not reimbursable as **targeted case management**, nor may the time spent by a targeted case manager be billed by a waiver case manager.

Payment cannot be made for targeted case management services for which another payer is liable nor for services for which no payment liability is incurred. Medicaid reimbursement is not available for services provided free of charge to non-Medicaid recipients, except as permitted for the State's Title V, Maternal and Child Health program under Section 1902 (a)(11)(B) of the Social Security Act.

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3 RECORD KEEPING

- A. The case manager must develop and maintain sufficient written documentation for each unit of targeted case management services billed. Documentation must include at least the following:
 - 1. Date of service
 - 2. Name of client
 - 3. Name of provider agency and signature of the individual providing the service
 - 4. Units of service - if service is a follow-up TCM activity
 - 5. Description of the case management activity related to the service plan
 - 6. Place of service
- B. Initial assessment documented as an individual completed form and must include all information found in the Initial Assessment form, with plan for follow-up services.
- C. Follow-up targeted case management services must be documented in 15-minute intervals.
- D. The following documents must be contained in each client's case file:
 - 1. A written individualized needs assessment which documents the client's need for targeted case management services
 - 2. A written individualized targeted case management service plan which identifies the services the client is to receive and who will provide them

4 SERVICE PAYMENT

4 - 1 Payment Methodology

- A. Payment for targeted case management services is made on a fee-for-service basis.
- B. Rates are prospective, adjusted for inflation and established on the basis of the historical cost for the service. A provider's initial rate is based on historical costs inflated by 3% per year. Rate adjustments are made on the basis of periodic cost studies. A separate rate is established for each type of targeted case management provider.
- C. The initial assessment is billed as a completed unit.
- D. Follow-up case management activities are rates based on a 15-minute unit of service.
- E. Payment cannot be made for targeted case management services for which another payer is liable nor for services for which no payment liability is incurred. Medicaid reimbursement is not available for services provided free of charge to non-Medicaid recipients, except as permitted for the State's Title V, Maternal and Child Health program under Section 1902(a)(11)(B) of the Social Security Act.

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5 TARGETED CASE MANAGEMENT CODES

5 - 1 Table Headings Defined

Code	The code is the Health Common Procedure Code System (HCPCS) code used by Medicaid to identify the item assigned by Medicaid. The procedure codes listed are the only ones accepted by Medicaid.
Age	Unless noted otherwise in this column, Medicaid covers the service or procedure from birth through age one. When an age range such as "0 - 1" is entered in this column, payment will be made only if the patient's age on the date of service falls within the age range specified. For example, "0 - 1" means from birth through age 1.
Criteria	The criteria listed are required by Medicaid before the item will be reimbursed and include criteria used by Medicaid staff to review a request for prior authorization.
Limits	Any limits applicable to a procedure code.

Coding Notes

Codes newly added to the list are in bold print.

A vertical line in the margin indicates where text or a descriptor changed for an existing code.

An asterisk (*) marks where a code is newly removed.

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5 - 2 Descriptions of Codes

CODES	DESCRIPTION	AGE	LIMITS
T1023	TCM for Newborns; Initial Assessment/each	0 - 4 years	1
T1017	TCM for Newborns/each 15 min.	0 - 4 years	99
S9453	Smoking Cessation Follow-up/Face to Face	12 - 55 years	1
S9453 -52	Smoking Cessation Follow-up/Telephone contact/each	12 - 55 years	2